ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 936 (6-2023)

Client Name (Last, First, Middle Initial)

I acknowledge that I have received the Department of Health and Human Services (Department) Notice of Privacy Practices, which includes information about the rights I have regarding my health information and how to obtain more information about the Department's privacy practices.

Signature	Date
If Legal Representative, Print Name	Relationship to Client

FOR DEPARTMENT USE ONLY

Reason Acknowledgment Could Not Be Obtained

- ☐ Client or legal representative refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other (specify reason): ______________________

Department Representative Signature is required if signed Acknowledgment is not obtained.

Printed Name of Department Representative	
Signature	Date